MEPS

Health Status and Limitations:
A Comparison of Hispanics, Blacks, and Whites, 1996

Research #10 Findings

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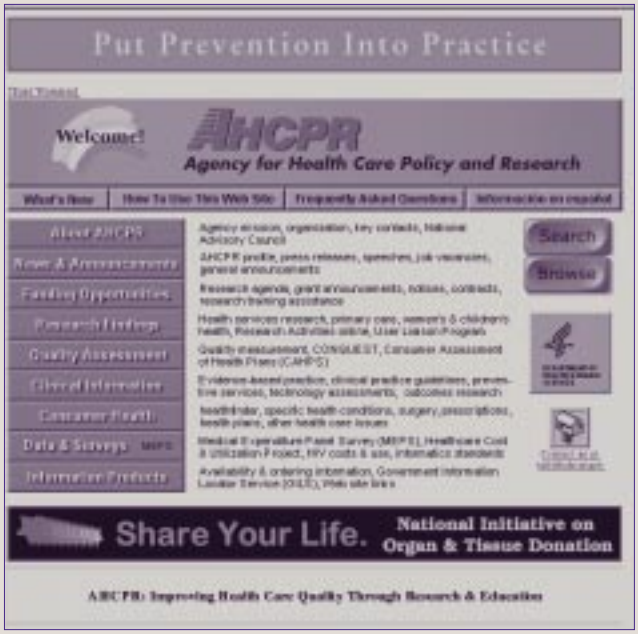

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Abstract

This report from the Agency for Health Care Policy and Research presents estimates of health status and limitations for the civilian noninstitutionalized population of the United States during calendar year 1996. Estimates are shown separately for Hispanics, blacks, and whites. Data are derived from the 1996 Medical Expenditure Panel Survey (MEPS) Household Component (HC). Health status was rated from excellent to poor by household respondents. Five types of functional limitations were assessed: activities of daily living (ADLs); instrumental activities of daily living (IADLs); limitations in physical activities such as walking; limitations in the ability to work, go to school, or do housework; and cognitive limitations. The report examines racial/ethnic differences in health status and limitation while taking into account other population characteristics—not only the large differences in age distribution across the three racial/ethnic groups but also characteristics such as sex, presence of a family wage earner, and health insurance status. Among the three racial/ethnic groups, fair or poor health was more likely among Hispanic children and among Hispanic and black non-elderly adults. The frequency of functional limitations by race/ethnicity was quite varied. Hispanics were less likely than blacks to have functional limitations. Among the elderly, blacks were much more likely than whites or Hispanics to have ADL or IADL limitations.

Suggested citation

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The Medical Expenditure Panel Survey (MEPS)

Background

The Medical Expenditure Panel Survey (MEPS) is conducted to provide nationally representative estimates of health care use, expenditures, sources of payment, and insurance coverage for the U.S. civilian noninstitutionalized population. MEPS also includes a nationally representative survey of nursing homes and their residents. MEPS is cosponsored by the Agency for Health Care Policy and Research (AHCPR) and the National Center for Health Statistics (NCHS).

MEPS comprises four component surveys: the Household Component (HC), the Medical Provider Component (MPC), the Insurance Component (IC), and the Nursing Home Component (NHC). The HC is the core survey, and it forms the basis for the MPC sample and part of the IC sample. The separate NHC sample supplements the other MEPS components. Together these surveys yield comprehensive data that provide national estimates of the level and distribution of health care use and expenditures, support health services research, and can be used to assess health care policy implications.

MEPS is the third in a series of national probability surveys conducted by AHCPR on the financing and use of medical care in the United States. The National Medical Care Expenditure Survey (NMCES) was conducted in 1977, the National Medical Expenditure Survey (NMES) in 1987. Beginning in 1996, MEPS continues this series with design enhancements and efficiencies that provide a more current data resource to capture the changing dynamics of the health care delivery and insurance system.

The design efficiencies incorporated into MEPS are in accordance with the Department of Health and Human Services (DHHS) Survey Integration Plan of June 1995, which focused on consolidating DHHS surveys, achieving cost efficiencies, reducing respondent burden, and enhancing analytical capacities. To accommodate these goals, new MEPS design features include linkage with the National Health Interview Survey (NHIS), from which the sample for the MEPS HC is drawn, and enhanced longitudinal data collection for core survey components. The MEPS HC augments NHIS by selecting a sample of NHIS respondents, collecting additional data on their health care expenditures, and linking these data with additional information collected from the respondents' medical providers, employers, and insurance providers.

Household Component

The MEPS HC, a nationally representative survey of the U.S. civilian noninstitutionalized population, collects medical expenditure data at both the person and household levels. The HC collects detailed data on demographic characteristics, health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment.

The HC uses an overlapping panel design in which data are collected through a preliminary contact followed by a series of five rounds of interviews over a 2½-year period. Using computer-assisted personal interviewing (CAPI) technology, data on medical expenditures and use for 2 calendar years are collected from each household. This series of data collection rounds is launched each subsequent year on a new sample of households to provide overlapping panels of survey data and, when combined with other ongoing panels, will provide continuous and current estimates of health care expenditures.

The sampling frame for the MEPS HC is drawn from respondents to NHIS, conducted by NCHS. NHIS provides a nationally representative sample of the U.S. civilian noninstitutionalized population, with oversampling of Hispanics and blacks.

Medical Provider Component

The MEPS MPC supplements and validates information on medical care events reported in the MEPS HC by contacting medical providers and pharmacies identified by household respondents. The MPC sample includes all hospitals, hospital physicians, home health agencies, and pharmacies reported in the

HC. Also included in the MPC are all office-based physicians:

- Providing care for HC respondents receiving Medicaid.
- Associated with a 75-percent sample of households receiving care through an HMO (health maintenance organization) or managed care plan.
- Associated with a 25-percent sample of the remaining households.

Data are collected on medical and financial characteristics of medical and pharmacy events reported by HC respondents, including:

- Diagnoses coded according to ICD-9 (9th Revision, International Classification of Diseases) and DSM-IV (Fourth Edition, *Diagnostic and Statistical Manual of Mental Disorders*).
- Physician procedure codes classified by CPT-4 (Current Procedural Terminology, Version 4).
- Inpatient stay codes classified by DRG (diagnosis-related group).
- Prescriptions coded by national drug code (NDC), medication names, strength, and quantity dispensed.
- Charges, payments, and the reasons for any difference between charges and payments.

The MPC is conducted through telephone interviews and mailed survey materials.

Insurance Component

The MEPS IC collects data on health insurance plans obtained through employers, unions, and other sources of private health insurance. Data obtained in the IC include the number and types of private insurance plans offered, benefits associated with these plans, premiums, contributions by employers and employees, and employer characteristics.

Establishments participating in the MEPS IC are selected through four sampling frames:

- A list of employers or other insurance providers identified by MEPS HC respondents who report having private health insurance at the Round 1 interview.
- A Bureau of the Census list frame of private-sector business establishments.
- The Census of Governments from the Bureau of the Census.
- An Internal Revenue Service list of the self-employed.

To provide an integrated picture of health insurance, data collected from the first sampling frame (employers and other insurance providers) are linked back to data provided by the MEPS HC respondents. Data from the other three sampling frames are collected to provide annual national and State estimates of the supply of private health insurance available to American workers and to evaluate policy issues pertaining to health insurance.

The MEPS IC is an annual panel survey. Data are collected from the selected organizations through a prescreening telephone interview, a mailed questionnaire, and a telephone followup for nonrespondents.

Nursing Home Component

The 1996 MEPS NHC was a survey of nursing homes and persons residing in or admitted to nursing homes at any time during calendar year 1996. The NHC gathered information on the demographic characteristics, residence history, health and functional status, use of services, use of prescription medications, and health care expenditures of nursing home residents. Nursing home administrators and designated staff also provided information on facility size, ownership, certification status, services provided, revenues and expenses, and other facility characteristics. Data on the income, assets, family relationships, and caregiving services for sampled nursing home residents were obtained from next-of-kin or other knowledgeable persons in the community.

The 1996 MEPS NHC sample was selected using a two-stage stratified probability design. In the first stage, facilities were selected; in the second stage, facility residents were sampled, selecting both persons in residence on January 1, 1996, and those admitted during the period January 1 through December 31.

The sampling frame for facilities was derived from the National Health Provider Inventory, which is updated periodically by NCHS. The MEPS NHC data were collected in person in three rounds of data collection over a 1½-year period using the CAPI system. Community data were collected by telephone using computer-assisted telephone interviewing (CATI) technology. At the end of three rounds of data collection,

the sample consisted of 815 responding facilities, 3,209 residents in the facility on January 1, and 2,690 eligible residents admitted during 1996.

Survey Management

MEPS data are collected under the authority of the Public Health Service Act. They are edited and published in accordance with the confidentiality provisions of this act and the Privacy Act. NCHS provides consultation and technical assistance.

As soon as data collection and editing are completed, the MEPS survey data are released to the public in staged releases of summary reports and microdata files. Summary reports are released as printed documents and electronic files. Microdata files are released on CD-ROM and/or as electronic files.

Printed documents and CD-ROMs are available through the AHCPR Publications Clearinghouse. Write or call:

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Additional information on MEPS is available from the MEPS project manager or the MEPS public use data manager at the Center for Cost and Financing Studies, Agency for Health Care Policy and Research, 2101 East Jefferson Street, Suite 500, Rockville, MD 20852 (301-594-1406).

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Health Status and Limitations: A Comparison of Hispanics, Blacks, and Whites, 1996

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Introduction

Perceived health status and functional limitations are key elements in health-related quality of life (Lohr, 1992). They also are closely associated with health care use and spending. Members of racial and ethnic minority groups frequently experience lower levels of health and health-related quality of life than whites do. However, racial and ethnic differences in health status must be examined carefully because the effects of factors such as socioeconomic status and culture can be masked by apparent racial effects (Schulman, Rubenstein, Chesley, et al., 1995; Williams, 1994). Therefore, careful analysis of health status among racial and ethnic groups is essential to understanding and addressing the health status inequalities found in American society.

This report provides national estimates of perceived health status and functional limitations for Hispanic, black, and white[2] members of the civilian noninstitutionalized population of the United States. Data on people in other racial/ethnic groups are not included. These estimates are based on data from Round 1 of the 1996 Medical Expenditure Panel Survey Household Component (MEPS HC). This report examines racial/ethnic differences in perceived health status and functional limitations while taking into account other population characteristics such as age, sex, presence of a family wage earner, and health insurance status.

Perceived health status was measured by asking respondents to rate their own health (and the health of all the members of their family) as excellent, very good, good, fair, or poor, when compared to other people of the same age. Additionally, five categories of functional limitations were assessed:

- Needing help with activities of daily living (ADLs), such as bathing or dressing.
- Needing help with instrumental activities of daily living (IADLs), such as shopping, making telephone calls, or paying bills.
- Having limitations in physical activities, such as walking, climbing stairs, lifting, or bending.
- Having limitations in the ability to work at a job, go to school, or do housework.
- Having cognitive limitations, such as confusion or memory loss.

Unless otherwise noted, only differences that were statistically significant at the .05 level are discussed in the text. A technical appendix provides detailed information on the MEPS HC, including data collection methods, instrument items, data editing, sample sizes, and statistical procedures for deriving estimates.

Population Characteristics

Table 1 presents a demographic profile of the Hispanic, black, and white U.S. civilian noninstitutionalized population. Of the total civilian noninstitutionalized population (including all racial/ethnic groups), 10.8 percent were Hispanic, 12.5 percent were black, and 72.2 percent were white.

Age

The age distribution varied significantly across the three racial/ethnic groups. Children under age 6 made up 14.1 percent of the Hispanic population and 11.1 percent of the black population but only 7.9 percent of the white population. Conversely, 14.1 percent of whites were age 65 and over, compared with only 5.2 percent of Hispanics and 8.1 percent of blacks. The large differences in age distribution among Hispanic, black, and white Americans have important implications for the health needs of these groups.

[1] Formerly with the Agency for Health Care Policy and Research.

[2] The ethnic category "Hispanic" can include people of all races. Therefore, the categories "black" and "white" exclude any people identified as being of Hispanic origin or ancestry. See the technical appendix for a more detailed description of racial/ethnic classifications.

Education and Family Wage Earner

There also were considerable differences in levels of adult education across the three racial/ethnic groups examined in this report. More than 40 percent of Hispanic adults (41.8 percent) and approximately one-quarter of black adults (26.2 percent) had less than 12 years of education, compared with only one-sixth of white adults (17.1 percent). In spite of dissimilar educational levels, Hispanics and whites were about equally likely to have at least one family member who was earning a wage.

Health Insurance

There were wide variations in health insurance status across the three groups. Among people under age 65, less than half of Hispanics (44.6 percent) and about half of blacks (49.9 percent) had private health insurance, while more than three-quarters of whites (76.7 percent) had private insurance. Lack of insurance was far more common among Hispanics (35.1 percent) than among either blacks (24.8 percent) or whites (15.2 percent).

Among people age 65 and over, Hispanics and blacks were more likely than whites to have only Medicare coverage, or to have Medicare as well as some other form of public health insurance (such as Medicaid). However, whites were about twice as likely to have Medicare combined with some form of private coverage (66.8 percent of whites 65 and over, compared to 33.4 percent of Hispanics and 34.2 percent of blacks).

Region and Place of Residence

Approximately 45 percent of the Hispanic population lived in the West Region of the United States. The largest proportion of blacks (55.6 percent) lived in the South. Hispanics and blacks were more likely than whites to live in a metropolitan statistical area (MSA).

Perceived Health Status

Increasingly, health services researchers and clinicians are recognizing the importance of people's own perceptions of their health in monitoring health care outcomes. Answers to simple questions—such as, "In general, compared to other people of the same age, would you say that your health (or your family member's health) is excellent, very good, good, fair, or poor?"—have been shown to predict demand for medical care services and medical care outcomes (Bowling, 1991; Ware and Sherbourne, 1992). Moreover, self- and family-reported health status have provided important insights on quality of life (Ware, 1984). Table 2 compares perceived health status measures for Hispanics, blacks, and whites, while holding constant four variables that have often been associated with differences in health status: age, sex, presence of a family wage earner, and health insurance status.

Age

In all age groups, whites were the least likely to be in fair or poor health

Hispanic children under age 18 were more frequently in fair or poor health (7.8 percent) than black children (4.2 percent) or white children (2.9 percent). These differences may seem small, but they are important because of the number of children involved: more than 2.6 million Hispanic, black, and white children were in fair or poor health (not shown).

Hispanics and blacks ages 18-64 were significantly more likely than whites to be in fair or poor health (17.4 percent and 16.1 percent, respectively, compared with 9.9 percent of whites) and less likely to be in excellent health (26.8 percent and 29.3 percent, respectively, compared with 34.6 percent of whites). Among adults age 65 and over, Hispanics and blacks also were more likely than whites to be in fair or poor health (36.9 percent and 40.4 percent, respectively, compared with 25.3 percent of whites).

Sex

Differences in health status by racial/ethnic group were found even within same-sex groups. Hispanic and black females were more likely to be in fair or poor health (16.9 percent and 15.3 percent, respectively) than white females (11.0 percent). Similarly, Hispanic and black males were more likely to be in fair or poor health (12.9 percent and 12.5 percent, respectively) than white males (9.6 percent). At the other end of the health rating scale, excellent health was less common among

Hispanic males (33.4 percent) than among black males (38.8 percent) or white males (39.6 percent).

Family Wage Earner

Within each of the three racial/ethnic groups examined in this report, people living in families without a wage earner were far more likely than people living in families with a wage earner to be in fair or poor health. For example, among whites, people living in families without a wage earner were almost three times as likely as people living in families with a wage earner to be in fair or poor health (19.6 percent compared with 6.8 percent).

When the comparison of health status by race/ethnicity is limited to people living in families with a wage earner, it can be seen that Hispanics were the most likely to be in fair or poor health (12.6 percent), followed by blacks (9.7 percent). Only 6.8 percent of whites living in families with a wage earner were in fair or poor health.

Health Insurance Status

This section is divided into information on people under age 65 and those age 65 and over.

Looking at the under-65 group, uninsured Hispanics and blacks were more likely than uninsured whites to be in fair or poor health (14.9 percent for Hispanics, 14.5 percent for blacks, and 9.9 percent for whites). In addition, only 28.4 percent of uninsured Hispanics had excellent health, compared with 36.6 percent of blacks and 37.7 percent of whites without insurance.

Among those under age 65, people with public health coverage were far more frequently in fair or poor health than privately insured people in the same racial/ethnic group. Comparing Hispanics, blacks, and whites with public insurance only (mostly Medicaid), there were no significant differences in the proportion who had excellent health. Similarly, there were no significant racial/ethnic differences in the proportion of privately insured people in excellent health. However, this lack of variation in health status across racial/ethnic groups when comparing people with similar insurance status must be viewed with caution. Younger people tend to have better health, and older people tend to have worse health. Compared with whites, a larger proportion of the Hispanic and black populations in the United States are under age 18. The difference in age distribution could make it appear that there are few health status differences among people with similar insurance status. For this reason, the next section, "Controlling for Insurance and Age," further analyzes health status variations across racial and ethnic groups.

Turning to those age 65 and over, blacks with Medicare as their only coverage were less likely to be in excellent health than Hispanics or whites with Medicare only (10.6 percent compared with 18.5 percent of Hispanics and 19.0 percent of whites). Further analysis of health status by racial/ethnic group for those age 65 and over is limited by small sample sizes.

Controlling for Insurance and Age

As Table 3 indicates, there were significant disparities in health status by racial/ethnic group when privately insured children under age 18 were compared. Privately insured Hispanic children were more likely to be in fair or poor health (4.2 percent) than privately insured white children (2.5 percent). The differences for Hispanics were even more pronounced among publicly insured children. Hispanic children covered only by public health insurance were twice as likely as publicly insured black or white children to be in fair or poor health (12.9 percent, compared to 6.3 percent of black children and 6.0 percent of white children). Among children who had no insurance at all, Hispanic children were less likely to be in excellent health (39.1 percent) than white children (55.8 percent).

Among adults ages 18-64 who had private health insurance, Hispanics and blacks were less likely than whites to be in excellent health and more likely to be in fair or poor health. Among adults who had no health insurance of any kind, Hispanics were less likely to be in excellent health (23.8 percent) than blacks (32.2 percent) or whites (32.3 percent). Both Hispanic and black adults who were uninsured were more likely than whites to be in fair or poor health (18.4 percent and 17.6 percent, respectively, compared with 12.3 percent of whites).

Functional Limitations

The concept of functional limitation addresses the effect that a disease or condition has on a person as a whole. For example, a person with arthritis in a knee

has a particular disease that may or may not create a functional limitation, such as an inability to climb stairs or walk long distances (Nagi, 1991). Like the overall measure of health status discussed previously, measures of functional limitation are based on a person's perceptions rather than a particular medical diagnosis of disease or disease severity. And like perceived health status, measures of functional limitation of this kind have been shown to be related to health care use and spending and to have important implications for health-related quality of life.

Functional limitations are often divided into two categories: limitations in the ability to perform activities of daily living (ADLs), such as bathing or dressing, and limitations in the ability to perform instrumental activities of daily living (IADLs), such as shopping, paying bills, and making phone calls. As Table 4 indicates, the Hispanic population ages 18-64 was less likely to need help with ADLs or IADLs (1.7 percent) than the black population this age (3.1 percent). Blacks age 65 and over were far more likely to report needing help with ADLs or IADLs (24.2 percent) than elderly Hispanics (17.0 percent) or whites (13.6 percent) were.

Among non-elderly adults, Hispanics were the least likely to have functional limitations.

Like ADLs and IADLs, cognitive limitations were less frequently reported for the Hispanic population ages 18-64 (2.4 percent) than for blacks in the same age group (3.6 percent). Across the three racial/ethnic groups, cognitive limitations among the elderly were not strikingly different.

Hispanics ages 18-64 were less likely than either blacks or whites of the same age to have difficulty with physical activities such as walking, climbing stairs, grasping objects, reaching overhead, lifting, bending or stooping, or standing for long periods of time (7.0 percent, compared with 9.7 percent of blacks and 9.0 percent of whites). Hispanics in this age group also were less likely to be limited in the ability to work at a job, go to school, or do housework because of an impairment or physical or mental health problem (5.0 percent) than blacks or whites in the same age group (8.4 percent and 7.2 percent, respectively). A combined measure of the four different types of limitations shows that Hispanics ages 18-64 had limitations less frequently (9.6 percent) than blacks (13.7 percent) or whites (12.6 percent) in the same age group.

The pattern was somewhat different for the age group 65 and over. Elderly Hispanics, like younger Hispanics, were the least likely to have limitations in the ability to work at a job, attend school, or do housework (20.3 percent). The proportion of elderly whites with work, school, or housework limitations (22.2 percent) was similar to that for Hispanics. Elderly blacks were considerably more likely to have limitations of this kind (29.6 percent). The proportion of elderly people having either physical activity limitations or any limitations at all did not differ significantly by race/ethnicity.

Table 5 profiles people who had some type of functional limitation (any one or more of the following: limitations in ADLs or IADLs, cognitive limitations, physical activity limitations, or work/school/housework limitations), comparing the age and sex distribution across the Hispanic, black, and white populations. Among people with functional limitations of any kind, more Hispanics and blacks than whites were relatively young (18-64 years). In the white population, a larger proportion of those with functional limitations were age 65 and over. There were no significant differences in the distribution of people with functional limitations by sex across the three racial/ethnic groups.

Conclusion

This report reveals some important differences in the perceived health status and level of functional limitations among Hispanics, blacks, and whites living in the United States. Hispanic children under age 18 were more likely than either black or white children to be in fair or poor health. Among adults ages 18-64, Hispanics and blacks were more likely than whites to be in fair or poor health; they also were less likely to be in excellent health.

Before researchers controlled for age, the comparisons indicated that Hispanics, blacks, and whites with private health insurance were equally likely to be in excellent health. However, when the large differences in age distribution across the three racial/ethnic groups were taken into account, significant differences in health status were found for both the privately insured and publicly insured groups. Specifically, Hispanics and blacks frequently had lower perceived health status than whites.

The frequency with which functional limitations were found across the three racial/ethnic groups was quite varied. Hispanics were less likely than blacks to have functional limitations. In the age group 18-64, Hispanics were less likely than whites to have physical activity limitations, work/school/housework limitations, or any limitations at all. Among those age 65 and over, blacks were far more likely than whites or Hispanics to have limitations in the ability to perform ADLs or IADLs, or to work at a job, go to school, or do housework.

The age distributions of people with some form of functional limitation were not equal across the three racial/ethnic groups. People with functional limitations were more likely to be under age 65 in the Hispanic and black populations than in the white population.

Health status and functional limitations varied in different ways across the three racial/ethnic groups. For example, Hispanics were more likely than whites to be in fair or poor perceived health but less likely to be reported as having functional limitations. The degree to which differences in health status and functional limitations across racial/ethnic groups are due to differences in age distribution, cultural differences in the definition of health and limitation, and other social and economic factors remains an important question. Although multivariate analysis would be needed to attempt to distinguish these complex relationships, the descriptive findings in this report suggest that important differences in the health status and frequency of functional limitations exist across racial and ethnic groups in the United States.

Subsequent releases of MEPS data will allow for additional analysis of health status by racial and ethnic groups, including analysis of some specific and highly prevalent conditions. It also will be possible to examine the relationship between health status, health care use and spending, and income and insurance status by racial and ethnic group. In this way MEPS will allow for more detailed consideration of the associations among demographic factors, socioeconomic status, racial/ethnic group membership, and health status.

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Table 1. Selected population characteristics—percent distributions for racial/ethnic groups: United States, first half of 1996

Population characteristics	Total population[a]	Hispanic[b]	Black	White
Total population in thousands	263,516	28,384	32,975	190,235
Percent of total U.S. population	100.0	10.8	12.5	72.2
	Percent distributions			
Age in years				
Under 6	9.1	14.1	11.1	7.9
6-17	18.0	22.5	23.1	16.5
18-64	60.8	58.2	57.7	61.5
65 and over	12.1	5.2	8.1	14.1
Education (adults)[c]				
Less than 12 years	20.4	41.8	26.2	17.1
12 years	34.2	29.6	37.2	34.6
More than 12 years	45.4	28.6	36.6	48.2
Presence of a family wage earner				
Yes	72.5	75.2	70.1	72.4
No	27.5	24.8	29.9	27.6
Health insurance status[d]				
Under 65 years				
Any private	68.7	44.6	49.9	76.7
Public only	12.1	20.3	25.2	8.1
Uninsured	19.2	35.1	24.8	15.2
65 years and over[e]				
Medicare only	28.1	38.9	39.1	26.4
Medicare and private	61.6	33.4	34.2	66.8
Medicare and other public	10.3	27.7	26.8	6.8
Region				
Northeast	19.5	15.4	17.1	20.8
Midwest	23.5	6.7	18.5	27.7
South	34.9	32.9	55.6	32.5
West	22.2	45.1	8.8	19.0
Metropolitan statistical area (MSA)				
MSA	79.9	90.8	84.5	77.0
Non-MSA	20.1	9.2	15.5	23.0

[a] In addition to whites, blacks, and Hispanics, total population figures include American Indians, Alaska Natives, and Asian or Pacific Islanders.

[b] Includes Hispanics of all races; the other race/ethnicity categories exclude Hispanics.

[c] Educational level of persons 18 years of age and over. Within each racial/ethnic group, a correction was applied to adjust totals for a small amount of item nonresponse on education.

[d] Health insurance status refers to health insurance during the first half of 1996. CHAMPUS/CHAMPVA (Armed-Forces-related coverage) is classified as public insurance.

[e] The small number of individuals age 65 and over who did not have Medicare are excluded from the analysis.

Note: Restricted to civilian noninstitutionalized population. Percents may not add to 100 due to rounding.

Source: Center for Cost and Financing Studies, Agency for Health Care Policy and Research: Medical Expenditure Panel Survey Household Component, 1996 (Round 1).

Table 2. Perceived health status by selected population characteristics—percent distributions for racial/ethnic groups: United States, first half of 1996

Population characteristics	Hispanic[a]				Black				White			
	Excellent	Very good	Good	Fair/ poor	Excellent	Very good	Good	Fair/ poor	Excellent	Very good	Good	Fair/ poor
Total population in thousands[b]	9,084	7,460	7,521	4,213	11,290	8,547	8,291	4,565	71,076	58,773	40,066	19,587
	Percent distributions											
Age in years												
Under 18	42.8	26.7	22.7	7.8	48.1	26.2	21.5	4.2	55.3	28.7	13.1	2.9
18-64	26.8	26.8	28.9	17.4	29.3	27.0	27.7	16.1	34.6	33.0	22.5	9.9
65 and over	15.8	19.4	27.9	36.9	14.3	19.9	25.4	40.4	19.1	26.3	29.3	25.3
Sex												
Male	33.4	27.2	26.5	12.9	38.8	26.9	21.9	12.5	39.6	30.4	20.4	9.6
Female	30.8	25.6	26.7	16.9	30.8	25.5	28.4	15.3	35.5	31.6	21.9	11.0
Family wage earner												
No	27.2	22.8	28.2	21.8	26.7	26.3	23.0	24.0	29.7	26.5	24.2	19.6
Yes	33.7	27.6	26.1	12.6	37.8	26.1	26.4	9.7	40.5	32.7	20.0	6.8
Health insurance[c]												
Under 65 years												
Any private	40.1	27.6	23.5	8.8	39.3	28.8	24.3	7.6	42.8	33.1	18.4	5.8
Public only	25.3	27.1	25.1	22.5	30.2	24.4	28.5	16.9	24.5	25.3	26.4	23.8
Uninsured	28.4	25.5	31.2	14.9	36.6	24.8	24.2	14.5	37.7	28.8	23.6	9.9
65 years and over												
Medicare only	18.5	22.1	30.3	29.1	10.6	18.6	31.4	39.4	19.0	25.0	30.2	25.8
Medicare and private	—	—	—	—	21.7	26.0	23.2	29.1	19.8	27.8	29.4	23.1
Medicare and other public	—	—	—	—	—	—	—	—	10.9	14.8	27.7	46.6

[a] Includes Hispanics of all races; the other race/ethnicity categories exclude Hispanics.

[b] Within each racial/ethnic group, a correction was applied to adjust totals for a small amount of item nonresponse on health status.

[c] Health insurance status refers to health insurance during the first half of 1996. CHAMPUS/CHAMPVA (Armed-Forces-related coverage) is classified as public insurance.

— Sample size is too small to support reliable estimation.

Note: Restricted to civilian noninstitutionalized population. Percents may not add to 100 due to rounding.
Source: Center for Cost and Financing Studies, Agency for Health Care Policy and Research: Medical Expenditure Panel Survey Household Component, 1996 (Round 1).

Table 3. Perceived health status by health insurance status[a] and age—percent distributions for racial/ethnic groups, United States, first half of 1996

Age[b] and perceived health status	Hispanic[c]			Black			White		
	Any private	Public only	Uninsured	Any private	Public only	Uninsured	Any private	Public only	Uninsured
Under 18 years				Number					
Total population thousands	4,133	3,373	2,868	4,701	4,604	1,980	34,698	6,070	5,669
				Percent distributions					
Excellent	54.7	31.5	39.1	54.7	41.0	48.7	58.1	38.2	55.8
Very good	22.4	30.9	27.9	25.0	29.3	21.9	28.3	31.8	28.1
Good	18.7	24.8	26.1	18.8	23.4	23.6	11.1	23.9	14.1
Fair/poor	4.2	12.9	6.9	*1.5	6.3	*5.9	2.5	6.0	*2.0
18-64 years				Number					
Total population in thousands	7,866	2,077	6,582	10,424	3,042	5,547	90,592	7,211	19,138
				Percent distributions					
Excellent	32.4	15.3	23.8	32.3	13.5	32.2	36.9	12.8	32.3
Very good	30.3	20.9	24.5	30.5	16.9	25.8	34.9	19.8	29.0
Good	26.1	25.7	33.3	26.9	36.3	24.4	21.2	28.6	26.4
Fair/poor	11.2	38.0	18.4	10.4	33.3	17.6	7.1	38.8	12.3

[a] Health insurance status refers to health insurance during the first half of 1996. CHAMPUS/CHAMPVA (Armed-Forces-related coverage) is classified as public insurance.

[b] Because of small numbers, people 65 and over are not included.

[c] Includes Hispanics of all races; the other race/ethnicity categories exclude Hispanics.

* Relative standard error is greater than 30 percent.

Note: Restricted to civilian noninstitutionalized population. Percents may not add to 100 due to rounding.

Source: Center for Cost and Financing Studies, Agency for Health Care Policy and Research: Medical Expenditure Panel Survey Household Component, 1996 (Round 1).

Table 4. Functional limitations—percent of adults with specific limitations by racial/ethnic group and age: United States, first half of 1996

Functional limitation	Hispanic[a]		Black		White	
	18-64 years	65 years and over	18-64 years	65 years and over	18-64 years	65 years and over
Total population in thousands	16,524	1,487	19,012	2,677	116,941	26,857
	Percent					
Any limitation	9.6	40.0	13.7	45.9	12.6	41.3
ADLs or IADLs[b]	1.7	17.0	3.1	24.2	2.2	13.6
Cognitive limitations	2.4	14.2	3.6	13.3	2.7	11.3
Physical activity limitations	7.0	34.3	9.7	39.0	9.0	35.6
Work/school/housework limitations	5.0	20.3	8.4	29.6	7.2	22.2

[a] Includes Hispanics of all races; the other race/ethnicity categories exclude Hispanics.

[b] Activities of daily living (ADLs) include activities such as bathing and dressing. Instrumental activities of daily living (IADLs) include activities such as shopping and paying bills.

Note: Restricted to civilian noninstitutionalized population. Percents may not add to 100 due to rounding. Because of small numbers, children under age 18 are not included.

Source: Center for Cost and Financing Studies, Agency for Health Care Policy and Research: Medical Expenditure Panel Survey Household Component, 1996 (Round 1).

Table 5. Functional limitations—percent distributions of adults with any functional limitation for racial/ethnic groups by age and sex: United States, first half of 1996

Age and sex	Hispanic[a]	Black	White
Total with any limitation[b] in thousands	2,177	3,835	25,847
	Percent distributions		
Age[c]			
18-64	72.8	68.0	57.1
65 years and over	27.2	32.0	42.9
Sex			
Male	38.2	40.4	41.0
Female	61.8	59.6	59.0

[a] Includes Hispanics of all races; the other race/ethnicity categories exclude Hispanics.

[b] Any limitation includes activities of daily living such as bathing and dressing, instrumental activities of daily living such as shopping and paying bills, cognitive limitations, physical activity limitations, and limitations in the ability to work at a job, go to school, or do housework.

[c] Because of small numbers, children under age 18 are not included.

Note: Restricted to civilian noninstitutionalized population. Percents may not add to 100 due to rounding.

Source: Center for Cost and Financing Studies, Agency for Health Care Policy and Research: Medical Expenditure Panel Survey Household Component, 1996 (Round 1).

Technical Appendix

The data in this report were obtained in the first round of interviews for the Household Component (HC) of the 1996 Medical Expenditure Panel Survey (MEPS). MEPS is cosponsored by the Agency for Health Care Policy and Research (AHCPR) and the National Center for Health Statistics (NCHS). The MEPS HC is a nationally representative survey of the U.S. civilian noninstitutionalized population that collects medical expenditure data at both the person and household levels. The focus of the MEPS HC is to collect detailed data on demographic characteristics, health conditions, health status, use of medical care services, charges and payments, access to care, satisfaction with care, health insurance coverage, income, and employment. In other components of MEPS, data are collected on the use, charges, and payments reported by providers; residents of licensed or certified nursing homes; and the supply side of the health insurance market.

The sample for the 1996 MEPS HC was selected from respondents to the 1995 National Health Interview Survey (NHIS), which was conducted by NCHS. NHIS provides a nationally representative sample of the U.S. civilian noninstitutionalized population and reflects an oversampling of Hispanics and blacks. Although the MEPS HC sample includes individuals in a wide variety of racial and ethnic categories, the data included in this report are limited to individuals reported by the survey respondent to be Hispanic (of any race), non-Hispanic black, or non-Hispanic white.

The MEPS HC collects data through an overlapping panel design. In this design, data are collected through a precontact interview that is followed by a series of five rounds of interviews over 2½ years. Interviews are conducted with one member of each family, who reports on the health care experiences of the entire family. Two calendar years of medical expenditure and utilization data are collected from each household and captured using computer-assisted personal interviewing (CAPI). This series of data collection rounds is launched again each subsequent year on a new sample of households to provide overlapping panels of survey data that will provide continuous and current estimates of health care expenditures. The reference period for Round 1 of the MEPS HC was from January 1, 1996, to the date of the first interview, which occurred during the period from March through July 1996.

Perceived Health Status

In every round of MEPS, the respondent is asked to rate the health of every member of the family. The exact wording of the question is: "In general, compared to other people of (PERSON)'s age, would you say that (PERSON)'s health is excellent, very good, good, fair, or poor?" The interviewer records the respondent's answers and also codes whether the answers represent a self-rating or a rating of the health of another family member.

There was a small amount of item nonresponse for the health status item (.37 percent among Hispanics, .85 percent among blacks, and .38 percent among whites). Within each racial/ethnic group, a correction was applied to redistribute item nonresponse across the categories.

Functional Limitations

Questions concerning the need for assistance in activities of daily living (ADLs) and instrumental activities of daily living (IADLs) are asked in every round of MEPS. All other questions concerning functional limitations are asked in Rounds 1 and 3.

IADLs and ADLs

Limitations in the ability to perform IADLs are assessed by first asking the respondent a screening question: "Does anyone in the family receive help or supervision using the telephone, paying bills, taking medications, preparing light meals, doing laundry, or going shopping?" If the respondent indicates that someone in the household receives help with these activities, a followup question is asked to determine which household member receives help. For persons under age 13, a final verification question is asked to confirm that the limitation is due to "an impairment or physical or mental health problem."

Limitations in the ability to perform ADLs are assessed with the following question: "Does anyone in the family receive help or supervision with personal care such as bathing, dressing, or getting around the house?" As with IADLs, a followup question identifies the individual with the limitation and, for children under the age of 13, another followup question confirms that the limitation is caused by an impairment.

Cognitive Limitations

Limitations in mental or cognitive functioning are assessed through a series of three questions about adults living in the family. The first question asks, "Does anyone in the family experience confusion or memory loss such that it interferes with daily activities?" The second question continues, "Does anyone in the family have problems making decisions to the point that it interferes with daily activities?" The third question asks, "Does anyone in the family require supervision for their own safety?"

Physical Activity Limitations

Limitations in physical activities are measured by asking, "Does anyone in the family have difficulties walking, climbing stairs, grasping objects, reaching overhead, lifting, bending or stooping, or standing for long periods of time?" For individuals age 13 and over who have physical activity limitations, a series of followup questions are asked to gather more detailed information about the nature and extent of the limitation. The data from the followup questions were not available for this report.

Work/School/Housework Limitations

These limitations include both paid work and unpaid housework, as well as limitations in ability to attend school. The relevant question asks, "Is anyone in the family limited in any way in the ability to work at a job, do housework, or go to school *because of an impairment or a physical or mental health problem?*" (emphasis in the question as indicated). For individuals identified as having a work/school/housework limitation, a followup question is used to clarify if the limitation applies to working at a job, doing housework, going to school, or some combination of the three. The data from the followup question were not available for this report.

Any Limitations

The measure "any limitations" is a combined measure that indicates whether an individual has one or more of the five types of limitations previously described: ADLs, IADLs, cognitive limitations, physical activity limitations, and limitations in the ability to work at a job, go to school, or do housework.

Population Characteristics

Information on all population characteristics used in this report comes from the MEPS HC Round 1.

Race/Ethnicity

Classification by race and ethnicity is based on information reported for each family member. Respondents were asked if each family member's race was best described as American Indian, Alaska Native, Asian or Pacific Islander, black, white, or other. They also were asked if each family member's main national origin or ancestry was Puerto Rican; Cuban; Mexican, Mexicano, Mexican American, or Chicano; other Latin American; or other Spanish. All persons whose main national origin or ancestry was reported in one of these Hispanic groups, regardless of racial background, were classified as Hispanic. Since the Hispanic grouping can include black Hispanic, white Hispanic, and other Hispanic, the race categories of black, white, and other do not include Hispanic. Only data for individuals identified as Hispanic (of any race), non-Hispanic black, and non-Hispanic white are included in this analysis.

Region and Place of Residence

Individuals were identified as residing in one of four main regions—Northeast, Midwest, South, and West—in accordance with the U.S. Bureau of the Census definition. Place of residence, either inside or outside a metropolitan statistical area (MSA), was defined according to the U.S. Office of Management and Budget designation, which applied 1990 standards using population counts from the 1990 U.S. census. An MSA is a large population nucleus combined with adjacent communities that have a high degree of economic and social integration with the nucleus. Each MSA has one or more central communities containing the area's main population concentration. In New England, metropolitan areas consist of cities and towns rather than whole counties.

Age

The respondent was asked to report the age of each family member as of the date of the Round 1 interview.

Education

Respondents were asked to report the highest grade or year of schooling ever completed by each family member 18 years of age and over as of the date of the Round 1 interview. There was a small amount of item nonresponse for education (1.40 percent among Hispanics, 1.17 percent among blacks, and .76 percent among whites). Within each racial/ethnic group, a correction was applied to adjust for item nonresponse so that the distribution of educational levels for each group adds to 100.0 percent.

Family Wage Earner

A family was defined as a group of people living together who were related to one another by blood, marriage, or adoption. Presence of a family wage earner was defined as having a person living in the family at the time of the Round 1 interview who was age 16 or over and had a paying job.

Health Insurance Status

The household respondent was asked if, between January 1, 1996, and the time of the Round 1 interview, anyone in the family was covered by any of the sources of public and private health insurance coverage discussed in the following paragraphs. For this report, Medicare and CHAMPUS/CHAMPVA coverage represent coverage as of the date of the Round 1 interview. (CHAMPUS and CHAMPVA are the Civilian Health and Medical Programs for the Uniformed Services and Veterans' Affairs.) All other sources of insurance represent coverage at any time during the Round 1 reference period. Persons counted as uninsured were uninsured throughout the Round 1 reference period. For additional details on health insurance status measures in MEPS, see Vistnes and Monheit (1997).

Public Coverage

For this report, individuals are considered to have public coverage only if they met both of the following criteria:

- They were not covered by private insurance.
- They were covered by one of the following public programs: Medicare, Medicaid, CHAMPUS/CHAMPVA, or other public hospital/physician coverage.

Private Health Insurance

Private health insurance is defined for this report as insurance that provides coverage for hospital and physician care. Insurance that provides coverage for a single service only, such as dental or vision coverage, is not counted.

Uninsured

The uninsured are defined as persons not covered by Medicare, CHAMPUS/CHAMPVA, Medicaid, other public hospital/physician programs, or private hospital/physician insurance throughout the entire Round 1 reference period. Individuals covered only by noncomprehensive State-specific programs (e.g., Maryland Kidney Disease Program, Colorado Child Health Plan) or private single-service plans (e.g., coverage for dental or vision care only, coverage for accidents or specific diseases) are not considered to be insured.

Sample Design and Accuracy of Estimates

The sample selected for the 1996 MEPS, a subsample of the 1995 NHIS, was designed to produce national estimates that are representative of the civilian noninstitutionalized population of the United States. Round 1 data were obtained for approximately 9,400 households in MEPS—comprising 23,612 individuals—which results in a survey response rate of 78 percent. This figure reflects participation in both NHIS and MEPS.

The statistics presented in this report are affected by both sampling error and sources of nonsampling error, which include nonresponse bias, respondent reporting errors, and interviewer effects. For a detailed description of the MEPS survey design, the adopted sample design, and methods used to minimize sources of nonsampling

error, see J. Cohen (1997), S. Cohen (1997), and Cohen, Monheit, Beauregard, et al. (1996). The MEPS person-level estimation weights include nonresponse adjustments and poststratification adjustments to population estimates derived from the March 1996 Current Population Survey based on cross-classifications by region, age, race/ethnicity, and gender.

Tests of statistical significance were used to determine whether the differences between populations exist at specified levels of confidence or whether they occurred by chance. Differences were tested using Z-scores having asymptotic normal properties at the .05 level of significance. Unless otherwise noted, only statistically significant differences between estimates are discussed in the text.

Rounding

Estimates presented in the tables were rounded to the nearest .1 percent. Standard errors, presented in Tables A-E, were rounded to the nearest .01. Therefore, some of the estimates for population totals of subgroups presented in the tables will not add exactly to the overall estimated population total.

Table A. Standard errors for selected population characteristics—percent distributions for racial/ethnic groups: United States, first half of 1996

Corresponds to Table 1

Population characteristics	Total population[a]	Hispanic[b]	Black	White
	Standard error			
Total population in thousands	5,512	1,405	1,937	4,441
Age in years				
Under 6	.26	.64	.83	.30
6-17	.36	.70	1.07	.42
18-64	.41	.80	1.08	.49
65 and over	.39	.49	.75	.47
Education (adults)[c]				
Less than 12 years	.61	1.61	1.51	.59
12 years	.58	.98	1.20	.72
More than 12 years	.88	1.48	1.57	.98
Presence of a family wage earner				
Yes	.69	1.26	1.80	.78
No	.69	1.26	1.80	.78
Health insurance status[d]				
Under 65 years				
Any private	.78	1.97	1.92	.87
Public only	.58	1.24	1.74	.59
Uninsured	.52	1.59	1.34	.57
65 years and over[e]				
Medicare only	1.16	3.81	3.94	1.27
Medicare and private	1.24	4.43	4.41	1.30
Medicare and other public	.76	3.05	3.94	.61
Region				
Northeast	.76	1.31	1.53	.96
Midwest	.93	.92	2.23	1.10
South	1.20	2.67	2.81	1.30
West	.75	2.41	1.39	.79
Metropolitan statistical area (MSA)				
MSA	.98	2.70	2.35	1.04
Non-MSA	.98	2.70	2.35	1.04

[a] In addition to whites, blacks, and Hispanics, total population figures include American Indians, Alaska Natives, and Asian or Pacific Islanders.

[b] Includes Hispanics of all races; the other race/ethnicity categories exclude Hispanics.

[c] Educational level of persons 18 years of age and over. Within each racial/ethnic group, a correction was applied to adjust totals for a small amount of item nonresponse on education.

[d] Health insurance status refers to health insurance during the first half of 1996. CHAMPUS/CHAMPVA (Armed-Forces-related coverage) is classified as public insurance.

[e] The small number of individuals age 65 and over who did not have Medicare are excluded from the analysis.

Note: Restricted to civilian noninstitutionalized population.

Source: Center for Cost and Financing Studies, Agency for Health Care Policy and Research: Medical Expenditure Panel Survey Household Component, 1996 (Round 1).

Table B. Standard errors for perceived health status by selected population characteristics—percent distributions for racial/ethnic groups: United States, first half of 1996

Corresponds to Table 2

Population characteristics	Hispanic[a]				Black				White			
	Excellent	Very good	Good	Fair/ poor	Excellent	Very good	Good	Fair/ poor	Excellent	Very good	Good	Fair/ poor
	Standard error											
Total population in thousands[b]	517	438	539	351	789	602	660	353	2,344	1,609	1,172	751
Age in years												
Under 18	2.02	1.51	1.51	.93	2.48	1.91	1.75	.69	1.16	.98	.72	.30
18-64	1.41	1.26	1.21	1.13	1.26	1.20	1.30	.98	.77	.57	.59	.40
65 and over	2.98	3.25	3.25	3.62	2.76	2.68	3.28	3.65	.97	1.15	.99	1.08
Sex												
Male	1.55	1.29	1.37	1.08	1.65	1.24	1.51	1.01	.79	.65	.54	.40
Female	1.55	1.25	1.04	.97	1.66	1.23	1.34	.91	.77	.63	.58	.48
Family wage earner												
No	2.03	1.61	1.82	1.56	1.76	1.98	1.63	1.94	1.03	.87	.80	.80
Yes	1.47	1.21	1.17	.88	1.79	1.12	1.39	.79	.75	.63	.52	.30
Health insurance[c]												
Under 65 years												
Any private	1.86	1.39	1.32	.77	1.89	1.41	1.49	.82	.80	.65	.53	.28
Public only	2.50	2.13	1.86	2.52	2.40	2.24	1.75	1.46	1.73	1.84	1.72	1.71
Uninsured	1.76	1.81	1.91	1.30	3.00	2.42	2.62	1.81	1.58	1.35	1.18	.78
65 years and over												
Medicare only	5.10	5.63	5.98	5.24	2.76	4.19	5.20	6.06	1.88	1.99	2.21	1.96
Medicare and private	—	—	—	—	5.93	4.97	5.24	5.75	1.25	1.44	1.19	1.37
Medicare and other public	—	—	—	—	—	—	—	—	2.63	3.30	3.63	4.33

[a] Includes Hispanics of all races; the other race/ethnicity categories exclude Hispanics.

[b] Within each racial/ethnic group, a correction was applied to adjust totals for a small amount of item nonresponse on health status.

[c] Health insurance status refers to health insurance during the first half of 1996. CHAMPUS/CHAMPVA (Armed-Forces-related coverage) is classified as public insurance.

— Sample size is too small to support reliable estimation.

Note: Restricted to civilian noninstitutionalized population.

Source: Center for Cost and Financing Studies, Agency for Health Care Policy and Research: Medical Expenditure Panel Survey Household Component, 1996 (Round 1).

Table C. Standard errors for perceived health status by health insurance status[a] and age—percent distributions for racial/ethnic groups: United States, first half of 1996

Corresponds to Table 3

Age[b] and perceived health status	Hispanic[c]			Black			White		
	Any private	Public only	Uninsured	Any private	Public only	Uninsured	Any private	Public only	Uninsured
	Standard error								
Under 18 years									
Total population in thousands	269	318	302	403	459	300	1,412	575	432
Excellent	2.96	3.15	3.12	3.02	3.20	6.60	1.31	2.93	2.72
Very good	2.32	2.62	3.04	2.50	3.17	4.30	1.11	3.28	2.38
Good	2.16	2.39	2.90	2.69	2.16	4.99	.85	2.70	1.89
Fair/poor	.81	2.22	1.48	*.46	1.25	*2.24	.31	1.08	*.74
Ages 18-64									
Total population in thousands	375	223	503	689	300	487	2,481	505	801
Excellent	1.86	2.65	1.65	1.81	2.59	2.51	.83	1.57	1.57
Very good	1.52	2.70	1.95	1.62	2.24	2.64	.67	2.07	1.44
Good	1.36	2.96	2.00	1.47	2.87	2.70	.59	2.30	1.34
Fair/poor	1.03	3.97	1.60	1.14	2.59	2.13	.33	2.53	.95

[a] Health insurance status refers to health insurance during the first half of 1996. CHAMPUS/CHAMPVA (Armed-Forces-related coverage) is classified as public insurance.

[b] Because of small numbers, people 65 and over are not included.

[c] Includes Hispanics of all races; the other race/ethnicity categories exclude Hispanics.

* Relative standard error is greater than 30 percent.

Note: Restricted to civilian noninstitutionalized population.

Source: Center for Cost and Financing Studies, Agency for Health Care Policy and Research: Medical Expenditure Panel Survey Household Component, 1996 (Round 1).

Table D. Standard errors for functional limitations—percent of adults with specific limitations by racial/ethnic group: United States, first half of 1996

Corresponds to Table 4

Functional limitation	Hispanic[a]		Black		White	
	18-64 years	65 years and over	18-64 years	65 years and over	18-64 years	65 years and over
	Standard error					
Total population in thousands	800	145	1,144	270	2,811	970
Any limitation	.74	3.51	.98	3.11	.47	1.27
ADLs or IADLs[b]	.36	2.88	.48	2.58	.19	.80
Cognitive limitations	.31	2.27	.49	2.27	.21	.83
Physical activity limitations	.68	3.35	.82	3.17	.39	1.30
Work/school/housework limitations	.57	2.95	.80	3.46	.35	1.07

[a] Includes Hispanics of all races; the other race/ethnicity categories exclude Hispanics.

[b] Activities of daily living (ADLs) include activities such as bathing and dressing. Instrumental activities of daily living (IADLs) include activities such as shopping and paying bills.

Note: Restricted to civilian noninstitutionalized population. Because of small numbers, children under age 18 are not included.

Source: Center for Cost and Financing Studies, Agency for Health Care Policy and Research: Medical Expenditure Panel Survey Household Component, 1996 (Round 1).

Table E. Standard errors for functional limitations—percent distributions of adults with any functional limitation for racial/ethnic groups by age and sex: United States, first half of 1996

Corresponds to Table 5

Age and sex	Hispanic[a]	Black	White
	Standard error		
Total with any limitation[b] in thousands	186	310	888
Age[c]			
18-64	2.89	2.79	1.50
65 and over	2.89	2.79	1.50
Sex			
Male	2.87	2.78	1.10
Female	2.87	2.78	1.10

[a] Includes Hispanics of all races; the other race/ethnicity categories exclude Hispanics.

[b] Any limitation includes activities of daily living such as bathing and dressing, instrumental activities of daily living such as shopping and paying bills, cognitive limitations, physical activity limitations, and limitations in the ability to work at a job, go to school, or do housework.

[c] Because of small numbers, children under age 18 are not included.

Note: Restricted to civilian noninstitutionalized population.

Source: Center for Cost and Financing Studies, Agency for Health Care Policy and Research: Medical Expenditure Panel Survey Household Component, 1996 (Round 1).

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